Bureau of TennCare/Medicaid

Provider Enrollment

310 Great Circle Road

Nashville, TN 37243 – 1700

TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
NO. 3 GROUP APPLICATION
www.state.tn.us/tenncare/Providers/enroll.html

(Check All That Apply)	
_____ **New Enrollment**	_____ **Change of Ownership**
_____ **MCC Medicaid No.**	_____ **Reactivation**
_____ **Medicare/Medicaid No.**	_____ **Adding Practice/Satellite Location**
	_____ **Name Change and Tax ID # Change**

Indicate Provider Type (Check One)

_____ **Clinic**	_____ **Group**	_____ **X-Ray Clinic**
_____ **Hospice**	_____ **Independent Lab**	**Nursing Homes:**
Hospital:	_____ **Ambulatory Surgical Ctr.**	_____ **ICF**
_____ **Acute**	_____ **DME Supplier**	_____ **SNF**
_____ **Critical Access**	_____ **Home Health Agency**	_____ **ICF/MR**
_____ **Rehabilitation**	_____ **Rural Health Clinic**	_____ **Other** _____

Legal Business Name: _____

D/B/A: _____

Practice Location: _____
(No P.O. Box #)

City: _____ **State:** _____ **Zip Code + 4:** _____

Telephone: _____ **Fax:** _____ **County:** _____

If the name and address to which checks and remittance advices are to be sent is different from the name and address above, please provide that information below. This pay-to information should match the W-9 form.

Legal Business Name as reported to the IRS: _____

Street Address or P.O. Box: _____
(Pay-To Address)
City: _____ **State:** _____ **Zip Code + 4:** _____

Telephone No.: _____ **Fax No.:** _____

Federal Tax No. (IRS No.): _____ **DEA No.:** _____

Applying For: Part A _____ **Part B** _____

Medical Specialty: _____

Briefly describe the services you propose to offer to Medicaid recipients: _____

_____

_____

Medical supplies and durable medical equipment only — briefly describe the types of items and equipment you propose to supply to Medicaid recipients:

_____

_____

Federal Medicare No.: _____ **State Medicaid No.:** _____

NPI Number: _____

Taxonomy: _____, _____, _____, _____

Submit copies of professional and/or business licenses, accreditations, certifications, and registrations specifically required to operate as a health care provider.

Date of Issuance: _____ **Expiration Date:** _____

Have you or any other owner, managing director, etc., related to this application ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs? Yes ____ No ____. If yes identify those person(s) by name and provide specifics for Medicaid evaluation. Attach this information to this application.

Please list the full name of every owner, with Social Security number and percent of ownership (required). If owned by corporation, please list corporate officers with same information. Use additional paper if necessary.

	Name	Title	SSN	% Ownership
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				

EFFECTIVE DATE FOR OPENING/REOPENING OFFICE: _____

EFFECTIVE DATE OF CHANGE OF OWNERSHIP: _____

If change of ownership, please provide the following:

Previous TN Medicaid Provider No. (if any): _____

Previous Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip Code + 4:** _____

IF A CHANGE OF OWNERSHIP HAS OCCURRED, DO NOT BILL ANY CLAIM FOR DATES OF SERVICE ON OR AFTER THE DATE OF OWNERSHIP CHANGE UNTIL YOU ARE NOTIFIED THAT THIS APPLICATION HAS BEEN ACCEPTED AND ENROLLMENT HAS BEEN COMPLETED. FAILURE TO FOLLOW THIS PROCEDURE MAY RESULT IN RECOUPMENT OF CLAIMS PAID.

Application Surety Statement: "I certify that the information provided on this application is complete and correct to the best of my knowledge."

Signature: _____ **Date:** _____

(Original Signature of Administrator, Agent, or Owner)

Printed Name: _____ **Title:** _____